DUDLEY CLINICAL COMMISSIONING GROUP BOARD

Date of Report: 9th January 2013
Report: Proposal for the reconfiguration of Urgent Care
Agenda item No: 8.2

TITLE OF REPORT:	Proposal for the reconfiguration of Urgent Care
PURPOSE OF REPORT:	The purpose of this report is to define the context and future options now available to Dudley CCG Board in regards to urgent care in Dudley. This paper builds on the comprehensive consultation process undertaken by the CCG, evaluates possible future service models and recommends the most robust and cost effective way forward.
AUTHOR OF REPORT:	Jason Evans – Commissioning Manager for Urgent Care
MANAGEMENT LEAD:	Paul Maubach – Chief Accountable Officer
CLINICAL LEAD:	Dr Steve Mann – Clinical Lead for Urgent Care
KEY POINTS:	• The current contracts for the Walk-in-Centre and Out-of-Hours contacts come to an end in September 2014. • The commissioning of new contracts provides an opportunity for Dudley CCG to adopt national guidance, fall in line with the CCG Primary Care Strategy and respond to the needs of local patients by re-designing these services into a simpler and more cost effective urgent care pathway. • The Board are asked to consider the 12 recommendations of this paper.
RECOMMENDATIONS:	**Recommendation 1:** that Board note the reconfiguration of Dudley urgent care system is in line with nation guidance and best practice; furthermore it falls in line with Dudley CCG Primary Care Strategy and they Dudley Health and Wellbeing Board June recommendations on urgent care. **Recommendation 2:** that the Board approve the rationale and evidence base to redesign the urgent care pathway for Dudley and as a minimum move to adopting scenario 3; thereby developing an integrated UCC on the Russells Hall NHS Trust site, adjacent to ED **Recommendation 3:** Our proposal in response to the issues raised by the public about the walk-in services is therefore two-fold: • Firstly, the ability to walk-in and obtain an assessment; especially at evenings and weekends; should be maintained. • Secondly, the out-of-hours service should be integrated into the walk-in service as part of the urgent care centre to create a new 24/7 service – thus extending the availability beyond the current arrangements. **Recommendation 4:** Our original proposal, in response to the issues raised in the consultation, should be modified to include bookable appointments at the urgent care centre and so reduce the impact to the public on the costs of parking at Russell's Hall. **Recommendation 5**: The CCG Board will therefore need to obtain assurance at a future meeting, as part of the procurement process, that the specification enhances the quality of the service to take account of the issues raised about Paediatrics, Mental Health and unregistered patients.

	Recommendation 6: The CCG Board should note that our IT strategy will enable further improvements to the connectivity and access to medical records in the future. **Recommendation 7:** The Board should report our conclusions to the Health and Wellbeing Board and seek endorsement for our planned way forward. **Recommendation 8:** Our Board is asked to: • confirm that it should be part of our strategic plan to develop joint commissioning arrangements [for GP services] with NHS England. • encourage Dudley Health & Wellbeing Board to invite NHS England, as a partner on the Board with the contractual responsibility for GP Access, to demonstrate how they intend to improve this in Dudley. • ask Dudley Health & Wellbeing Board to support joint commissioning between the CCG and NHS England as a key opportunity for addressing this issue. **Recommendation 9:** Our Board is asked to note: • that the current development support arrangements that we have put in place for GPs, have made, and continue to make, an important contribution to improving access to GPs but will be insufficient longer-term both; without additional resources and without working with the public to change patterns of behaviour and expectation. • that the risk of GP access deteriorating would place unmanageable pressures on walk-in services **Recommendation 10:** Our Board is asked to approve that we should encourage the development of PPGs with all practices and ensure future plans on improving access require their input **Recommendation 11:** Our Board is asked to confirm that the newly commissioned urgent care centre is initially designed to accommodate the planning assumptions in scenario 3; but should incorporate the flexibility to move to scenario 5 **Recommendation 12**: approve that we commence the development of the service specification to produce a detailed proposal at the March Board meeting, at which point we will also have received the feedback from the Health and Wellbeing Board.
FINANCIAL IMPLICATIONS:	This premise of this proposal is that it will be financially neutral. However, there would be capital costs associated with the establishment of the UCC and the ability to provide funding to improve GP access will be dependent on two things: firstly that support is available from NHS England and secondly moving towards scenario 5.
WHAT ENGAGEMENT HAS TAKEN PLACE:	Extensive stakeholder, patient and public engagement has been undertaken – See Urgent Care Consultation Outcomes Report (Agenda item 8.1)
ACTION REQUIRED:	✓ Approval ✓ Decision Assurance

DUDLEY CLINICAL COMMISSIONING GROUP BOARD – 9th JANUARY 2014
PROPOSAL FOR THE RECONFIGURATION OF URGENT CARE IN THE BOROUGH OF DUDLEY

CONTENTS

1. INTRODUCTION

The purpose of this report is to define the context and future options now available to Dudley CCG Board in regards to urgent care in Dudley. This paper builds on the comprehensive consultation process undertaken by the CCG, evaluates possible future service models and recommends the most robust and cost effective way forward.

In line with the vision of the CCG Board, current national recommendations on urgent care and the findings of the recent consultation process, this paper will recommend the procurement of an Urgent Care Centre (UCC) located on the Russells Hall NHS Trust site, adjacent to the Emergency Department (ED). A service outline for the proposed UCC is also included in section 6 of this paper which provides an overview of the key elements of the proposed new service. Twelve recommendations are offered for The Board to consider at the end of the paper.

2. REPORT

The principles underpinning the redesign of the unscheduled and urgent care in Dudley is affirmed by many resent national publications and urgent care analysis. The NHS England publication 'High quality care for all now and for future generations: Transforming Urgent and Emergency Care Services in England (Revised November 2013)', asserts that "the diverse nature of urgent care services causes confusion amongst patients and healthcare professionals." It further states that "this confused picture can cause the lack of standardised clinical practice amongst differing services and a lack of clear information given to patients" and that "this variation can cause a delay in access to appropriate treatment, multiple contacts with different clinicians and ultimately a poor experience for the patient."

The Royal College of Physicians publication in June 2013 'Urgent and emergency care – a prescription for the future' also identified ten priorities for action by commissioners. Alongside recommendations for acute trusts the report stated there should be:

- Effective and simplified alternatives to hospital admission across seven days
- The promotion of greater collaboration within the hospital and beyond to manage emergency patients

- The commissioning and planning emergency care services that focus on ambulatory emergency care, setting out which admissions are avoidable, and what proportion should be more appropriately managed in the community.

Significantly these best practice approaches and principles are reaffirmed in the Keogh review 'Transforming Urgent Care Services in England (November 2013)'. In summary the review recommended from the extensive public, clinical and commissioner engagement undertaken that there was clear evidence base for:

> *The co-location of community-based urgent care services in coordinated Urgent Care Centres. These will be locally specified to meet local need, but should consistently use the "Urgent Care Centre" name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of–hours GP services. Considering all local facilities in this way will mean that networks will need to examine the extent of duplication or gaps in service offered by all of these facilities currently. Urgent Care Centres may also be advantaged by co-location with hospital services, particularly in urban areas.*

At a more local level the redesign of urgent care has been a core component of the CCG's Primary Care Strategy and also a focus of Dudley Health and Wellbeing Board. In June 2013 the first 'Spotlight Event' was held with the Health and Wellbeing Board on 'urgent and emergency care'. Outcomes from the event included agreement on a set of key principles relating to what a future urgent care system might include. The principles were as follows:

- A joined up, coordinated and seamless system, fluid- no 'bottle necks'
- A simple system-no confusion for the public (or professionals) of what to do, who to call or where to go
- Safe, responsive and high quality

One of the solutions the event delegates identified was to work to simplify the urgent care system, reduce duplication and develop a system which responded to patients' 'default behaviour.' Specific proposals from the event included "co-locate the walk in centre, with the emergency department."

Furthermore, prior to starting this public consultation, our GPs reviewed the current arrangements and concluded that a co-located and integrated urgent care centre would provide the clinically most appropriate and safest service for patients (both simplifying the service and as a result resolving the existing risk of patients self-presenting to the wrong service). Our GPs also concluded that this new arrangement should be developed in conjunction with improving weekday access to general practice in order to ensure as many patients as possible are able to appropriately attend their local practice as the service best able to meet their needs.

3. CURRENT SERVICE CONFIGERATION

As a result of overwhelming national and local support for change the CCG has sought to develop a vision forward. The recent CCG urgent care consultation confirms that for some patients there is a fragmented and confusing model of urgent care in Dudley. The current configuration of unscheduled care in Dudley is as follows:

Provider	Contracted service	Service provided	Location	Hours
Primecare	Walk in Centre	Primary Care	Holly Hall Clinic	08:00 to 20:00 Mon – Friday (08:00 to 10:00 seven days a week throughout Winter Pressures
Primecare	Out of Hours service	Primary Care	Holly Hall Clinic	18:30 to 08:00 and 24 hours on Saturday to Sunday and Bank Holidays
49 Dudley GPs	Primary Care	Primary Care	Locations across the whole borough	Core hours between 8am-6.30pm on weekdays, varies by practice
Dudley Group of Hospitals NHS FT	Accident and Emergency services	Primary Care and Major cases	Russells Hall Hospital	24 hours a day 365 days a year

4. SCENARIO DETAIL AND ESTIMATED ACTIVITY LEVELS

The following section offers detail and estimated activity levels for five possible scenarios. These have been developed in response to the consultation and in response to a steer from the chair of the Health and Wellbeing Board in order to help illustrate how the issues raised both before and during the consultation will or will not be resolved in different circumstances. These scenarios are as follows:

Scenario 1 - 'Do nothing' and simply re-commission the walk-in-centre and out-of-hours contracts in their existing form at their current sites.

Scenario 2 - re-commission the walk-in-centre and out-of-hours contracts in their existing form but specify in the contract that the service must be provided from the Russells Hall NHS Trust site adjacent to ED.

Scenario 3 - Commission a 24/7 UCC combining out-of-hours provision, provided from the Russells Hall NHS Trust site adjacent to ED.

Scenario 4 - Commission a 24/7 UCC combining out-of-hours provision, provided from the Russells Hall NHS Trust site adjacent to ED. Invest in GP in-hours access which would result in some patients (10%) changing their current behaviour to preference GP services – but don't redirect them to those services.

Scenario 5 - Commission a 24/7 UCC combining out-of-hours provision, provided from the Russells Hall NHS Trust site adjacent to ED. Invest in GP in-hours access and include arrangements to redirect all non-urgent cases from the UCC back to their own registered GP practice.

Scenario 5 reflects the vision that was proposed in the urgent care consultation as this incorporates:

- the development of an integrated Urgent Care Centre;
- the active triage of patients at the UCC both into the emergency department, into urgent primary care at the centre, or back to the patients' practice or other appropriate services;
- improving GP access to see more patients during the day on week-days

The follow tables summarises the current levels of activity and how these levels may change dependant on the five scenarios:

Scenario 1	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Walk in Centre	1,626	24,409	1,550	23,259	50,844
Out of Hours Service			1,005	19,635	20,640
A&E	11,447	28,682	18,427	38,981	97,537
Total	13,073	53,091	20,982	81,875	169,021
Assumes current service configeration remains (Do nothing and re-commission existing serivces)					

Scenario 2	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Walk in Centre	1,626	24,409	1,550	23,259	50,844
Out of Hours Service			1,005	19,635	20,640
A&E	11,447	28,682	18,427	38,981	97,537
Total	13,073	53,091	20,982	81,875	169,021
Assumes current Service configuration remains but is moved to Russells Hall NHS Trust site					

Scenario 3	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Urgent Care Centre	8,629	28,061	14,122	50,409	101,221
A&E	4,444	25,030	6,860	31,466	67,800
Total	13,073	53,091	20,982	81,875	169,021
Assumes all Primary Care A&E cases are managed by the Urgent Care Centre					

Scenario 4	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Urgent Care Centre	7,766	25,255	14,122	50,409	97,552
A&E	4,444	25,030	6,860	31,466	67,800
Total	12,210	50,285	20,982	81,875	165,352
Assumes 10% of in-hours cases previously using the UCC, use GP services					

Scenario 5	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Urgent Care Centre	7,766	842	14,122	1,512	24,242
A&E	4,444	25,030	6,860	31,466	67,800
Total	12,210	25,872	20,982	32,978	92,042
Assumes all non-urgent redirected except for unregistered patients					

5. HOW THESE SCENARIOS REFLECT THE PUBLIC CONSULTATION

The pre-consultation and subsequent consultation identified several issues that need to be considered in redesigning the services.

5.1 MOVING FROM SCENARIO ONE TO SCENARIO THREE

5.1.1 Proposed co-location and integration of walk-in, out-of-hours and A&E services

The first key component of our consultation was to recommend that we close the existing walk-in service and create a new integrated urgent care centre at the Russell's Hall site. To demonstrate the implications of this change: scenario one assumes no change; scenario two assumes merely locating the services on the same site but without any redesign; and scenario three models the impact of creating an integrated service.

There is a clear steer both from national guidance and from our own local assessments that this proposal (ie: scenario three) is the most clinically appropriate thing to do and will provide a better service for our population.

In the public consultation very clear concerns were expressed that people do not want to see a deterioration in the accessibility that the walk-in service provides (see next section) however no-one provided any challenge or counter argument to the national guidance or to our own prior assessment that this change would be the most clinically appropriate thing to do.

There were three concerns that were raised about the transfer of the service to the Russell's Hall site.

Firstly, a concern that the co-location would create added pressure on the existing A&E services. This concern is however, unfounded. In fact it will reduce the pressure on the emergency department. This is because a significant number of patients who self-present and are currently treated at the A&E merely have a primary care need. Therefore these patients would be triaged by the Urgent Care Service and seen by the primary care service. The model (comparing scenario three to scenario one) shows that an integrated service would therefore significantly reduce the numbers of patients who would need to be seen by the A&E. The change is also supported by Dudley Group FT as significantly improving the way the services would operate.

Secondly a few individuals queried whether Russell's Hall is more accessible than Holly Hall. But in fact the hospital site is much better served by public transport and the two locations are very close – only 7 minutes walk apart.

Thirdly a concern that was consistently raised in many meetings, and in individual responses is the cost of parking at Russell's Hall.

So the first issue that we have to consider is whether the concerns about the cost of parking at the site outweigh the clinical benefits, national guidance and local assessment that creating an integrated service would provide. i.e: That scenario three is better than scenario one.

For completeness, we have included scenario two, but in fact this provides none of the benefits of scenario three together with the pain of parking costs.

Recommendation 1: that Board note the reconfiguration of Dudley urgent care system is in line with nation guidance and best practice; furthermore it falls in line with Dudley CCG Primary Care Strategy and they Dudley Health and Wellbeing Board June recommendations on urgent care.

Recommendation 2: that the Board approve the rationale and evidence base to redesign the urgent care pathway for Dudley and as a minimum move to adopting scenario 3; thereby developing an integrated UCC on the Russells Hall NHS Trust site, adjacent to ED

5.1.2 Accessibility of walk-in services and primary care out-of-hours services

These two existing services are contracted for separately; albeit provided by the same organisation. The pre-consultation public survey results for the out-of-hours services indicated that it provides poor levels of patient satisfaction. In contrast the public survey and subsequent feedback from the public consultation for the current walk-in service demonstrates very high levels of patient satisfaction.

It is clear that people like the ease of use of the walk-in service and there are lessons to be learnt from this in the provision of the out-of-hours service. However the walk-in service currently only operates from 8am-8pm (extended to 10pm over the winter period).

It is important to note that, with the creation of an urgent care centre, there would have to be the provision of a 24/7 service because the centre would have to be able to triage patients between A&E and the urgent Primary Service.

Recommendation 3: Our proposal in response to the issues raised by the public is therefore two-fold:

- Firstly, the ability to walk-in and obtain an assessment; especially at evenings and weekends; should be maintained.
- Secondly, the out-of-hours service should be integrated into the walk-in service as part of the urgent care centre to create a new 24/7 service – thus extending the availability beyond the current arrangements.

This would then provide a significant enhancement to the way the current services are provided.

5.1.3 Providing telephone advice and booking

There has been a clearly expressed preference that people would like to be able to access reliable telephone advice that can provide reassurance and/or direct them to the most appropriate service. In particular, parents with ill children would find this extremely helpful. This endorses the need for NHS 111 and the service that they already provide.

NHS 111 is now fully in place but the feedback from the consultation reveals a lack of confidence in the current service. It is unclear whether this is informed through practical experience or whether this is perception or lack of awareness.

In our consultation we proposed that people should be able to phone 111 for advice or to make an urgent appointment with their local GP the next day. However, we could modify this concept to enable the 111 service to make appointments for patients at the urgent care centre. The front desk of the urgent care centre would triage all walk-in patients: into providing advice, into the primary care component of the service, or into the emergency department. So the telephone service could triage patients in the same way and either solely provide advice, make direct appointments for patients if needed into the primary care component of the service; or advise on the need to go to the emergency department.

This aspect of the telephone service with bookable appointments would have three distinct benefits:

- Patients who don't need either primary care or emergency care would not have to go to the urgent care centre at all;
- Patients who get a booked appointment would then not have to wait in the way they would if they walked-in to the centre; and so would spend considerably less time at the centre;
- Both of these outcomes would either avoid, or significantly reduce the time spent at Russell's Hall and would therefore substantially mitigate against the cost of parking at the site.

Recommendation 4:
Our original proposal, in response to the issues raised in the consultation, should be modified to include bookable appointments at the urgent care centre and so reduce the impact to the public on the costs of parking at Russell's Hall.

5.1.4 Improving the quality of the walk-in and OOH services

There are some important issues which have been identified in this process which will need to be addressed, regardless of where and how the services are provided

- A disproportionately high proportion of cases are paediatrics – so it will be important to ensure that any new service is tailored to meet this need.
- Concerns have been raised about the timeliness and accessibility to mental health services as part of these arrangements
- The service will need to provide urgent care to unregistered patients – but also actively encourage those patients to register with a GP

These are issues which will need to be addressed as part of the development of the specification for a new service. A more detailed analysis of the Healthwatch interviews will also help to inform the specification.

Recommendation 5: The CCG Board will therefore need to obtain assurance at a future meeting, as part of the procurement process, that the specification enhances the quality of the service to take account of these issues.

5.1.5 Improving connectivity and access to medical records

Another concern expressed by both our GPs and by the public is that current A&E, WIC and OOH services do not have access to full patient records. This is one of the reasons why there is a clear preference for people to access their GP rather than a WIC service because they will be seen by a service that knows them and has their full medical history.

An additional consequence is also that the A&E, WIC and OOH services are necessarily less efficient than GP services because the former have to undertake consultations which include taking information from the patient that would otherwise be readily available to the latter on their medical records.

Our IT strategies will help to improve this situation over the next few years. It is our preferred intention to migrate all GPs over to using the same system. Once this is achieved it would then be possible to provide integrated access to the GP records to the other urgent care services – and so improve the efficiency and effectiveness of those services.

Recommendation 6: The CCG Board should note that our IT strategy will enable further improvements to the connectivity and access to medical records in the future.

5.1.6 Overall assessment on creating an integrated Urgent Care Centre

It is our view that the establishment of an Urgent Care Centre as a replacement for the existing walk-in and out-of-hours services is an essential requirement to improving the provision of urgent care in Dudley and that this is consistent with Dudley Health and Wellbeing Board's strategic vision.

Recommendation 7: The Board should report our conclusions to the Health and Wellbeing Board and seek endorsement for our planned way forward.

5.2 MOVING FROM SCENARIO THREE TO SCENARIO FIVE

5.2.1 The importance of good GP access

The overwhelmingly most significant issue raised both before and during the public consultation was around the public's preference for improved GP access; tempered with scepticism as to whether this can be achieved.

Our consultation included in the vision our belief that the individual's own GP is the best 'navigator' for their health needs and care. They hold the records and have all of the medical history on which to make the safest healthcare decisions.

Our model proposed that local GPs should be the first place that they go for urgent care and that they should get all of their basic health care at the local surgery during week days. We also identified that this would need additional GP appointments during week days, at the expense of providing a walk-in service during week days.

Our model also proposed that the new urgent care service should be available to provide the walk-in and out-of hours care when the local GP service is closed.

Scenario three assumes that either no attempt is made to improve GP access or that the attempt to improve access does not deliver any reduction in demand for the Urgent Care Centre.

Scenario four assumes that we improve GP access but that we do not direct people to use those service as a first choice, and so reductions in the use of the UCC are limited to public behavioural change.

Scenario five assumes that we improve GP access and that we also direct people to use the most appropriate service so that the maximum benefits in matching need to service are achieved.

The importance of good access to GP services cannot be underestimated. The current walk-in-centre represents a tiny proportion (less than 3%) of the total number of primary care appointments that are available across Dudley borough. The vast majority of the service is provided by our GPs and only a very small proportion of patients either choose, or feel they have no choice other than to use, the existing walk-in service.

We should therefore recognise the current success of GP services and we should perhaps consider that the biggest risk to urgent care delivery is not: can we improve GP access further? But what if current pressures on GP services result in a shift in demand to walk-in services?

A 1% reduction in availability of GP services could create a 33% increase in demand for walk-in services. Whereas a 50% reduction in walk-in capacity would create only a 1.5% pressure on GP practices. So there is an obvious risk, that a failure to support improving GP access may actually result in undeliverable pressures on the walk-in service.

It is therefore encouraging that the public feedback from the consultation places a much greater importance on the need to support GP access, rather than on the need to rely upon walk-in services; and this therefore supports the need to move away from scenario three towards scenario five.

However public feedback from the consultation both supports and challenges our proposals on improving GP access:

How does it support our proposals?

There is a clear public preference for more same-day appointments in General Practice and for more flexibility on booking when you can see your GP (eg: in two or three days' time, rather than having to choose between an emergency or weeks in advance).

There is also clear evidence from those who use the existing walk-in service that they would be happy to see their own GP if they could.

And there is also clear evidence that people would be happy to be redirected to see their own GP if they could access the service and that people should use services appropriately and not abuse the system – which supports the move from Scenario 4 to Scenario 5.

How does it challenge our proposals?

There is a clear public preference for more early and late opening for GP services and for weekend opening of GP services. This in effect, therefore asks for us to take our plans well beyond what we are currently proposing. However we do raise these issues as part of the longer-term considerations in our primary care strategy.

There is also a clear public scepticism, particularly expressed by local councillors, that we won't be able to improve GP access because the CCG does not have the contractual responsibility for this – NHS England does.

How does this affect the priority for this in our proposals?

No-one was saying that the objective to improve GP access was not relevant or that we should not be aiming to try and do something to support it.

There was overwhelming agreement that this should be our most important priority out of all the issues identified during the consultation.

5.2.2 Can we improve GP access?

The role of NHS England and the CCG

NHS England has the contractual responsibility for GP access. Therefore NHS England will have to consider the outcome of this consultation and consider how it will address the issues that have been raised.

It is therefore reasonable for the public to raise concerns about the extent to which Dudley CCG can address the issues of GP access in isolation, without cooperation from NHS England.

However, Dudley CCG is working in partnership with NHS England and we have already established some joint arrangements together - both with the establishment of a joint performance review group; with NHS England membership on the CCG's Primary Care Development Committee; and with shared endorsement of our primary care strategy through the Health and Wellbeing Board.

There is nevertheless, as a consequence of the national reforms, a disconnect between the CCG responsibility for funding walk-in services (in-hours) and the NHSE responsibility for funding GP services (in-hours). To some extent, the rising pressure on the former could be considered as consequentially arising from the commissioning failure by the latter – ie: NHSE's failure to adequately address access results in more people using walk-in services when they would rather see their own GP.

This challenge could be better addressed by further improved integration between the CCG and NHS England on how we commission these comparable and interconnected services.

In addition, the CCG holds the responsibility for quality improvement in general practice. However whilst our CCG has extensive support arrangements in place for working with our practices; our effectiveness in achieving these aims is inevitably partially hindered by the limitations on how we can invest resources.

This limitation could also be better addressed by improved integration between the CCG and NHS England – so we should be seeking to bring our improvement responsibilities for these services, together with NHSE's contractual responsibilities for these services, into a more formalised joint commissioning arrangement.

Current evidence for improving GP access

The public are saying that GP access is the single most important quality issue arising from this consultation; and so given our responsibilities, we have already been undertaking work with our practices to support improvements.

Dudley CCG has been providing a wide range of development support to practices since its inception. This support is detailed in the Primary Care Strategy and it is our view that this has helped practices to meet the year-on-year rise in demand without the need for additional resources. This is evidenced by the fact that demand for A&E services has not risen over the last few years.

In addition, Dudley CCG invited all practices to work with the Primary Care Foundation, funded with non-recurrent resources, to review their current access arrangements and there has been 100% take up from our practices to do this. As a result of this work, practices are already looking at how they can make improvements and are sharing their experiences with each other in our locality meetings. This will be brought together over the next 2 months to set out the opportunities and existing improvements that are already being made.

Two case study examples are illustrated below.

Practice case study one:
An online service for booking appointments and requesting repeat prescriptions

In late 2013, the practice set in train a number of improvements that will help reduce the number of calls coming in and free receptionists to pick up the telephone when they do. For a start, patients can now book appointments and request repeat prescriptions online.

The online services will help increase the accessibility of the practice, by reducing the number of calls and increasing the capacity to answer them.

Practice case study two:
Regular review of the calls coming into the practice and the appointments available means the practice can flex to meet changing demand

The focus of the practice is on making sure the practice can respond quickly to changing demand by looking in detail at the appointment requests coming in.
The change is not just in the volume of calls to the surgery but also for the type of appointments people need. Sometimes there is a surge in demand for same day appointments; other times more people are looking for regular appointments to discuss an on-going health issue. For example, Mondays and Thursdays have proven to be high demand days for same day appointments so on those days, the practice now allocates more slots to same day appointments.
By looking in detail at the demand, the practice can make more of the types of appointments available when people need them. The practice team aims to smooth the peaks and troughs making for a better patient experience and a better working environment.

These demonstrate the commitment of GPs in Dudley to respond to the challenges on access. They also show; though innovative working; that it is possible to make some improvements with modest investment and without having to expand the number of existing appointments.

However, some of these changes will have already been implemented by other practices so it would be incorrect to assume that this is the answer to solving all access issues. Each practice will need to be considered separately; a one-size-fits all approach won't work; and it would be naïve to assume that the current levels of increasing demand can continue to be met both; without additional resources and without working with the public to change patterns of behaviour and expectation.

<u>Reviewing access with each practice.</u>

Access to GPs is variable (there are 49 practices) and that variability is determined by both how the practices work and also by what their patients expect from their practice. Each practice supports a different population with different needs and has a different level of funding from NHS England to meet that need.

We have also heard from the public through the consultation that some people speak very highly of their practice and have no difficulties in accessing services (and the vast majority of people get their services from their GP); other people make a choice to sometimes use their practice and at other times use the walk-in service; some people over-use the service and will repeat attendance at all available services; whilst other people are not happy with their GP service and consequently choose to go to the walk-in centre.

So how should we define good access and how should we determine what is required for each practice.

Our view is that whilst there are some important themes that will be consistent between practices 'what does good access look like' is a question that should be answered between the practice and their patients; and both the CCG and NHS England should be actively supporting this. There is a mutual responsibility that should be shared:

- by the public to not use services inappropriately and so create unnecessary demand;
- between the practice and their patients to understand what good access means for them;
- between the practices the commissioners and the population to ensure there is sufficient capacity and capability in total to meet overall need.

So a key component to improving access is to include the public in that process. We are addressing this by

- prioritising the development of the practice participation groups (PPGs);
- supporting the groups to work with their practices on these issues;
- and including representation from those groups to inform our overall planning for the services

Out of the 49 practices we now have 33 PPGs established, with a further 8 practices wanting to set one up. It would add real strength to the role of these PPGs if it was made a requirement that any future investment in improving access with practices should be developed with PPGs.

5.3 How the modelled scenarios reflect the issues raised by the consultation

The table below summarises how the scenarios reflect the issues raised through the consultation.

Issue	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
National Policy Issues					
Is service model consistent with principles set out in NHSE 'High Quality Care' document?	No	No	Yes	Yes	Yes
Is service model consistent with Keogh proposals in 'Transforming Urgent Care'?	No	No	Yes	Yes	Yes
Is service model consistent with recommendations from Royal College of Physicians	No	No	Yes	Yes	Yes

Local Issues					
Is it consistent with proposals to improve and simplify urgent care locally set out by HWBB?	No	No (because although co-located, not simplified)	Yes	Yes	Yes
Is it consistent with views of CCG's GP membership and clinical leaders about urgent care?	No	No	Partly (addresses co-location but not improving GP access)	Partly (addresses co-location but limits amount of investment in improved GP access)	Yes
Is it consistent with the aims of the CCG's Primary Care Strategy?	No	No	No	Yes	Yes
Issues Raised During Consultation					
Does it meet public requirements for a good quality service?	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification
Does it provide a service for patients who are not registered with a GP?	Yes	Yes	Yes	Yes	Yes
Does it support improvements to GP access during weekday day times?	No	No	No	Yes	Yes
Does this reduce the pressure on GP services?	No	No	No	No	No
Does this avoid increasing the burden on GPs?	Yes	Yes	Yes	No (unless extra funding available)	No (unless extra funding available)
Does this release savings for reinvestment in GP services?	No	No	No	Partly (subject to agreement from NHS England)	Yes (subject to agreement from NHS England)
Does this reduce pressure on ED?	No	No	Yes	Yes	Yes
Does this support an affordable option for longer opening hours for walk-in services?	No	No	Yes	Yes	Yes
Is parking free?	Yes	No	No	No	No
Will the site be better serviced by public transport	No	Yes	Yes	Yes	Yes

Will this improve access to patient's own GP outside normal working hours (i.e. at evenings and weekends)?	No	No	No	No	No
Will it support provision of more help and advice by telephone?	Yes - Subject to appropriate use of 111	Yes- Subject to appropriate use of 111	Yes - Subject to appropriate use of 111	Yes - Subject to appropriate use of 111	Yes -Subject to appropriate use of 111
Does this support improvements to other services (for example mental health)?	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification
Does this encourage more appropriate use of urgent care services?	No	No	Partly (simplifies choice)	Partly (simplifies choice)	Yes (simplifies choice and directs patients to most appropriate treatment)

5.4 Conclusions

There are actions that we can take to improve access to general practice and therefore enable a movement from scenario three to scenario five.

However this is challenging!

The public challenge and scepticism on achieving improvements is therefore reasonable. So it would be prudent to ensure that any newly commissioned urgent care centre is initially designed to accommodate the planning assumptions in scenario 3; but should incorporate the flexibility to move to scenario 5 as sufficient improvements in GP access are realised.

Recommendation 8: Our Board is asked to:

- confirm that it should be part of our strategic plan to develop joint commissioning arrangements [for GP services] with NHS England.
- encourage Dudley Health & Wellbeing Board to invite NHS England, as a partner on the Board with the contractual responsibility for GP Access, to demonstrate how they intend to improve this in Dudley.
- ask Dudley Health & Wellbeing Board to support joint commissioning between the CCG and NHS England as a key opportunity for addressing this issue.

Recommendation 9: Our Board is asked to note:

- that the current development support arrangements that we have put in place have made, and continue to make, an important contribution to improving access to GPs but will be insufficient longer-term both; without additional resources and without working with the public to change patterns of behaviour and expectation;
- that the risk of GP access deteriorating would place unmanageable pressures on walk-in services

Recommendation 10: Our Board is asked to approve that we should encourage the development of PPGs with all practices and ensure future plans on improving access require their input

Recommendation 11: Our Board is asked to confirm that the newly commissioned urgent care centre is initially designed to accommodate the planning assumptions in scenario 3; but should incorporate the flexibility to move to scenario 5

6. DRAFT SERIVCE OUTLINE FOR DUDLEY UCC

Should the Board choose scenario 3, moving to scenario 5 over time, the follow sections offer a useful outline definition and service specification of the proposed Urgent Care Centre (UCC). The purpose of the UCC could usefully be defined as:

> *To develop a coherent 24/7 urgent care service in the Borough of Dudley that makes sense to patients when they have to make choices about their care. This will provide streaming / triage for the front door of ED, if required urgent medical care with a clinical professional and a seamless relationship with 111.*

6.1 UCC Aims

Draft service aims for the UCC is offered below and would require the following service requirements:

- An Urgent Care Centre (UCC) providing a primary care triage service through bookable appointments 24 hours a day, 7 days a week.
- The delivery of a seamless interface between 111 (currently provided by WMAS), face-to-face streaming / triage and consultations with a clinical professional during the in-hours and out-of-hour's period.

6.2 UCC Objectives

A provider would be commissioned to deliver the best standards of health care that meets the patients need or perceived need through consistent assessment via a 'primary care triage' model of service. Upon entering the triage system a patient will be referred back to their GP, provided with advice, booked into a face-to-face clinical consultation at the UCC or directed to the ED. This service would be available in the UCC 24 hours a day 7 days a week. There would be 3 main routes into the service by patients:

1. They walk into the UCC and if appropriate are offered a booked appointment.
2. They call 111 (In-hours and Out-of-Hours) and if appropriate are offered a bookable appointment with an Advanced Nurse Practitioner (ANP) or General Practitioner (GP) at the UCC.
3. They are referred by another local provider such as ED (where blue light patients have been identified as not being appropriate for ED), WMAS non-urgent ambulance or a local GP.

6.3 Draft UCC Service Outline

The UCC would provide a consistent 24/7 assessment of patients who are booked into an appointment for the service by 111. The majority of these bookable appointments would be outside of GP core hours. Ambulatory patients would also be seen who may have accessed the service by walking into the centre and are very ill but do not require 999 services.

For ambulatory patients the UCC address patient's needs or perceived needs by face-to-face initial assessment by the triage 'reception and registration' facility. A trained receptionist (this model is in operation in Walsall UCC) gives appropriate response to the patient's perceived need. Following this initial visual assessment and if the patient is sufficiently ill they are offered an appointment at the UCC with an ANP or GP. At this clinical assessment patients are again triaged and may follow one of the following routes, based on clinical risk:

- Seen, treated and discharged
- Booked for diagnostic and imaging services
- Held for further observation
- Streamed to another Trust service i.e. plastering facility and subsequently to an outpatient's clinic e.g. fracture clinic
- Streamed to the Emergency Department
- Transferred to another Healthcare provider, which could include their own GP
- Signposted to Rapid Response Service
- Signposted to a local Pharmacy

6.4 Accessibility/acceptability

The UCC will act as a single point of access for all self-presenting cases at Russells Hall Hospital ED through a common reception gateway. Appropriate cases may also be diverted to the service by WMAS, ED or community based providers. The inclusion criteria for the UCC could be as follows:

Presentation	In Hours	Out of Hours
Registered with Local GP	Urgent - UCC see and treat	Urgent - UCC see and treat
	Non urgent - Refer back to own GP or Advise on self-treatment	Assessed as Non urgent - Refer back to own GP
Not registered with Local GP (out of area, regionally / nationally)	Urgent - UCC see and treat	Urgent - UCC see and treat
	Non urgent - Refer back to own GP or Advise on self-treatment	Assessed as Non urgent - Refer back to own GP
Not Registered with any GP	UCC see and treat - Signpost to practice near place of residence if local	UCC see & treat - Signpost to practice near place of residence if local

This description is consistent with scenario 5. The is only one difference in this model between scenario 5 and scenarios 3 and 4; namely: in scenarios 3 and 4 all non-urgent cases requiring a GP would be seen by the UCC rather than redirected back to their own GP.

The Out-of-Hours period is defined as 18:30 – 08:00 hours, Monday –Thursday and 18:30hrs Friday – 08:00 Monday at weekends plus bank holidays.

The In-hours period is defined as 0801 – 1829 hours Monday- Friday (excluding bank holidays)

6.5 Out of Scope

Dental Services would be out of the scope of the service unless a patient had protracted dental bleeding, trauma or swelling to the face i.e. rapidly spreading infection; these patients may be seen in the UCC or immediately be streamed to ED.

6.6 Service Delivery

There are five service elements to the UCC and Out of Hours provision that would need to be commissioned and coordinated as summarised below:

1) Initial **self-presentation** of patients in the UCC is met by face-to-face triage by a receptionist. The receptionist undertakes a primary assessment using a visual and question based assessment formulary. The receptionist then streams the patient to an appropriate service i.e. back to their own GP, a booked appointment in the UCC or if sufficiently serious direct referral to ED.

2) **Face to face consultation and treatment** - In hours and Out-of-Hours patients at the UCC are booked an appointment via 111 or the UCC receptionist for a face-to-face consultation conducted by an ANP or GP. A clinician would offer treatment, including assessment, diagnosis, treatment or treatment plan, onward referral, follow-up, or discharge and prescribing of medicines as required.

3) Initial access to Out-of-Hours services and associated **call handling** will be provided by 111. There would need to be a seamless approach between 111 and the UCC. An effective relationship between the two would ensure the 111 system would:

   a. Enable filtering out of unnecessary referrals to the UCC according to agreed prioritisation and referral protocols.
   b. Continue to provide a real-time local information and advice service to signpost patients to other services (e.g. local pharmacies etc.) and direct patients to their GP as required.
   c. Identify and fast-tracks potentially life-threatening conditions to WMAS via 999.

4) 111 provide the Out-of-hours **assessment and advice** service via a telephone assessment service through trained health care professionals. On the patients request or if deemed necessary 111 would:

   - Offer a definite clinical assessment of the patient needs conducted by an appropriately trained clinician working to an agreed clinical protocol (e.g. if not a GP) and within a defined clinical governance framework agreed by the CCG.
   - Offer a course of treatment which may include:
     - Advice on self-management.
     - A telephone consultation providing advice on self-care.
     - A booked invitation to attend the UCC for a face-to-face consultation with a clinician
     - A home visit planned for a face to face consultation with a clinician
     - Advice to patients to contact their own GP during the opening hours of their GP surgery.
     - Referral to another service i.e. Rapid response, Social services, Community Nursing, Mental Health, Dentistry, Local Authority Services etc.
     - Onward referral to another out-of-hours, urgent or emergency service.

- Advice to patient to contact their local Walk in Centre (if not patient of Dudley GP practice) where these are available.

5) 111 provide the current out-of-hours **home visiting** service which receives its workload from the telephone assessment service. 111 will continue to provide a home (home is considered to be where the patient normally resides and may be a care home) visiting service to all patients whom, in the reasonable opinion of the telephone assessment service, and in the light of the patient's medical condition and/or significantly difficult social circumstances (being "functionally housebound"), it would not be reasonable to expect to be able to travel to the UCC.

6.7 Premises for Urgent Care Centre and Out-Of-Hours Service

The UCC will be located on the Russells Hall NHS Trust site, adjacent to ED. 111 call handling and telephone triage elements of the service are located on a separate site and provided by WMAS.

7. PROCUREMENT IMPLICATIONS

A significant amount of work still needs to be undertaken to define the model, produce a detailed service specification and determine the type of service contract to be used if scenarios 3-5 are agreed.

The procurement procedure for this tender will be the restricted procedure, an advert will be placed in Supply2Health and a pre-qualification process will be undertaken to devise a shortlist of potential bidders to be taken forward to the final invitation to tender stage.

Dudley CCG should consider tendering the new service for a period of not less than three years and preferably for up to five years, as implementation of the new service may require significant capital expenditure to secure suitable premises on the Russells Hall NHS Trust site and clinical and non-clinical equipment. An initial contract term of up to five year will enable the successful provider or Prime Contractor to recoup any capital expenditure invested in the service.

A contract term of up to five years will also provide assurance to Dudley Group of Hospitals NHS Trust as landlords of the OOH site of Dudley CCG's commitment to support a viable site for the UCC.

7.1 Timescales for procurement

The procurement of the service (with agreement of the Board) will need to ensure that a contract is awarded by the 1st October 2014 and allowing three months for the mobilisation of the service.

This affords very little time for delay in determining the detailed service specification and so this process should begin as soon as possible. The development of the specification will need to include appropriate provider, patient and public representation. This will need to establish key performance standards and use both the issues identified in this report as well as further detailed analysis that can be taken from the Healthwatch questionnaires.

Recommendation 12: The Board is asked to approve that we commence the development of the service specification to produce a detailed proposal at the March Board meeting, at which point we will also have received the feedback from the Health and Wellbeing Board.

9. CONCLUSION

The case for the redesign of unscheduled care services remains strong. This paper represents the rational and draft service outline in which to define the vision to redesign urgent care in Dudley into a coherent, viable and safe future service provision. It is acknowledged that the draft service outline will require significant expansion, clinical scrutiny and refinement to enable a full service specification to be finalised in preparation for the procurement process.

10. RECOMMENDATIONS

Recommendation 1: that Board note the reconfiguration of Dudley urgent care system is in line with nation guidance and best practice; furthermore it falls in line with Dudley CCG Primary Care Strategy and they Dudley Health and Wellbeing Board June recommendations on urgent care.

Recommendation 2: that the Board approve the rationale and evidence base to redesign the urgent care pathway for Dudley and as a minimum move to adopting scenario 3; thereby developing an integrated UCC on the Russells Hall NHS Trust site, adjacent to ED

Recommendation 3: Our proposal in response to the issues raised by the public about the walk-in services is therefore two-fold:

- Firstly, the ability to walk-in and obtain an assessment; especially at evenings and weekends; should be maintained.
- Secondly, the out-of-hours service should be integrated into the walk-in service as part of the urgent care centre to create a new 24/7 service – thus extending the availability beyond the current arrangements.

Recommendation 4:
Our original proposal, in response to the issues raised in the consultation, should be modified to include bookable appointments at the urgent care centre and so reduce the impact to the public on the costs of parking at Russell's Hall.

Recommendation 5: The CCG Board will therefore need to obtain assurance at a future meeting, as part of the procurement process, that the specification enhances the quality of the service to take account of the issues raised about Paediatrics, Mental Health and unregistered patients.

Recommendation 6: The CCG Board should note that our IT strategy will enable further improvements to the connectivity and access to medical records in the future.

Recommendation 7: The Board should report our conclusions to the Health and Wellbeing Board and seek endorsement for our planned way forward.

Recommendation 8: Our Board is asked to:

- confirm that it should be part of our strategic plan to develop joint commissioning arrangements [for GP services] with NHS England.
- encourage Dudley Health & Wellbeing Board to invite NHS England, as a partner on the Board with the contractual responsibility for GP Access, to demonstrate how they intend to improve this in Dudley.
- ask Dudley Health & Wellbeing Board to support joint commissioning between the CCG and NHS England as a key opportunity for addressing this issue.

Recommendation 9: Our Board is asked to note:

- that the current development support arrangements that we have put in place have made, and continue to make, an important contribution to improving access to GPs but will be insufficient longer-term both; without additional resources and without working with the public to change patterns of behaviour and expectation;
- that the risk of GP access deteriorating would place unmanageable pressures on walk-in services

Recommendation 10: Our Board is asked to approve that we should encourage the development of PPGs with all practices and ensure future plans on improving access require their input

Recommendation 11: Our Board is asked to confirm that the newly commissioned urgent care centre is initially designed to accommodate the planning assumptions in scenario 3; but should incorporate the flexibility to move to scenario 5

Recommendation 12: approve that we commence the development of the service specification to produce a detailed proposal at the March Board meeting, at which point we will also have received the feedback from the Health and Wellbeing Board.

Jason Evans
Commissioning Manager – Urgent Care
8th January 2014